State of California Health and Welfare Agency

ANNUAL UTILIZATION REPORT - 1997

Hospitals

STATE USE ONLY

Page 0, Line 1

STATUS 3 ____ CONSOL # 6 ___

Return **BY FEBRUARY 15, 1998** to:
Office of Statewide Health Planning
and Development
Licensed Services Data Section
818 K Street, Rm. 500
Sacramento, CA 95814

Completion of the "Annual Utilization Report of Hospitals" is required by Section 127285 of the Health and Safety Code, and is a requirement for the licensure of your health facility pursuant to Section 70735 and 71533 of Title 22 of the California Code of Regulations. Failure to complete and file this report by February 15, may result in action against the facility's license.

If you have any questions please contact the Office at (916) 322-7422.

"I declare the following under penalty of perjury: that I am the current administrator of this facility, duly authorized by the governing body to act in an executive capacity; that I am familiar with the record keeping systems of this facility and the records and logs are true and correct to the best of my information and belief; that I have read this annual report and am thoroughly familiar with its contents; and that its contents represent an accurate and complete summarization from our medical records and logs of the information requested."

_____
Administrator's Name (Please Print)

_____
Name of person completing form and /or contact person for any follow-up questions (Please Print)

_____
Administrator's Signature

_____
Print Title and Department of Person Responsible for the Report

_____
Date

(____) _____
Area Code Phone Ext.

3. (____) _____
Area Code Facility Phone Number

(____) _____
Area Code FAX Number

COMPLETE PART A ONLY IF THE FACILITY WAS DELICENSED (CLOSED), WENT INTO SUSPENSE OR NEWLY LICENSED IN 1996.

A. DATES OF LICENSURE: If the facility was licensed on 1/1 or after or was delicensed (closed) or went into suspense on 12/31 or before, enter the dates of operation on Line 1, Columns 1 and 2. Month = 01 through 12 and Day = 01 through 31.

		Col. 1			Col. 2		
11.	FROM	Month	Day	THROUGH	Month	Day	

COMPLETE PART B & C ONLY IF THE FACILITY WAS NEWLY LICENSED OR CHANGED LICENSEE/ OWNERSHIP IN 1997.

B. LICENSEE (OWNERSHIP) TYPE:
From the list below, select the ONE category that best describes the type of ownership (licensee) of your facility and enter the number which appears next to that category. .....2. _____

LICENSEE (OWNERSHIP) CODES		
NONPROFIT	**FOR PROFIT**	**STATE/LOCAL GOVERNMENT**
18 Nonprofit Corporation	23 Individual	11 State
19 Kaiser	24 Partnership	12 County
20 Church Related	25 Corporation	13 City
22 University of California		14 City/County
21 Other _____ Specify		15 Hospital District

C. PRINCIPAL SERVICE TYPE:
From the list below, select the ONE category that best describes the type of service provided to the majority of your patients and enter the number which appears next to that category.....3. _____

PRINCIPAL SERVICE CODES		
10 General Medical/Surgical	14 Tuberculosis and Other Respiratory Disease	18 Rehabilitation (Physical Rehab)
11 Hospital Unit of an Institution (e.g. Penal Institution, student health)	15 Chemical Dependency (Alcohol/Drug)	19 Orthopedic or Pediatric Ortho
12 Long Term Care (SN/IC)	16 Chronic Disease	22 Developmentally Disabled
13 Psychiatric	17 Pediatric	23 Other _____ (Specify)

A. HOSPICE PROGRAM

Enter the number 1 if the facility offered a hospice program during the calendar year?..... 1 ____
(A hospice is a centrally administered program of palliative and supportive services which provide physical, psychological, social and spiritual care for dying persons and their families, focusing on pain and symptom control for the patient. Care is available by a coordinated interdisciplinary team seven days a week, 24 hours a day and extends through the bereavement period.)

If yes, what type of bed classification is used for this service?
1-General Acute Care, 2-SNF, 3-ICF, 4-Combination..... 2 ____

LONG TERM CARE SERVICES
(SKILLED NURSING AND/OR INTERMEDIATE CARE (SN/IC)

B. CERTIFICATION:

From the certification categories below, place a check on those categories for which your facility was certified or contracted during the year.

Medicare:	**Medi-Cal:**	**Medi-Cal:**	**Medi-Cal:**	**Medi-Cal**
Skilled Nursing	Skilled Nursing	Intermediate Care	Intermediate Care/DD	Subacute
Line 5 (Col. 1) ___	(Col. 2) ___	(Col. 3) ___	(Col. 4) ___	(Col. 5) ___

C. Length of Time in Facility--All patients discharged: (See definition of "discharge" in instruction booklet.)

TABLE A

Time in Facility	Line No.	Number of Patients
TOTAL DISCHARGES	11	*
Less than 2 weeks	12	
2 weeks less than 1 month	13	
1 month less than 3 months	14	
3 to 6 months	15	
7 to 12 months	16	
1 year less than 2	17	
2 years less than 3	18	
3 years less than 5	19	
5 years less than 7	20	
7 years less than 10	21	
10 years or more	22	

*Total discharges must be the same on page 4, line 3, column 6. (Table B)

D. SPECIAL PROGRAMS FOR HOSPITAL BASED LTC'S

During the calendar year, what was the number of patients diagnosed as having AIDS, ARC, prodromal AIDS or HIV related disease and illness (HTLV-III/LAV)?.....41_____

Enter the number 1 if your facility offered a specialized program for Alzheimer's patients?.....42_____

During the calendar year, what was the number of patients who had a primary or secondary diagnosis of Alzheimer's Disease? .....43_____

COMPLETE THE TABLE USING THE FOLLOWING:

(Line 1) + (Line 2) - (Line 3) = Line 4

The sum of line 2 (ADMISSIONS) columns 7-12 must equal the amount shown on line 2 column 6 (**Total**)

The sum of line 3 (DISCHARGES) columns 7-14 must equal the amount shown on line 3 column 6 (**Total**)

The sum of line 4 (CENSUS) columns 7-14 must equal the amount shown on line 4 column 6 (**Total**)

Line 2, Col. 7-12
Place Admitted From

Line 3, Col. 7-14
Place Discharged To

		SN (Gen)	IC (Gen)	SN (MD)	IC (DD)	Total	Home	Hospital	State Hospital	Other LTC	Residential Bd & Care	Other	AWOL	Death
Dec.31, 1996 Census	Ln. 1													
(+) Admissions	Ln. 2													
(-) Discharges	Ln. 3													
Dec.31, 1997 Census	Ln. 4													
Patient Days	Ln. 5						**7 Medicare**	**8 Medi-Cal**	**9 HMO**	**10 Priv. Ins.**	**11 Priv. Pay**	**12**	**13**	**14 Other**
Licensed Beds	Ln. 6													
Licensed Bed Days	Ln. 7													
Swing Beds	Ln. 8													
	Cols.	**1**	**2**	**3**	**4**	**6**								

Line 4, Col. 7-14 Reimbursement By Payer Source

Refer to Instruction Booklet

TABLE B

A. TOTAL NUMBER OF LTC PATIENTS

1. Number of Patients in the Facility on December 31 of the Reporting Year..... _____
2. Number of **Male** Patients on December 31 of the Reporting Year..... _____
3. Number of **Female** Patients on December 31 of the Reporting Year..... _____

B. RACE /ETHNICITY AND AGE OF MALE LTC PATIENTS ON DECEMBER 31.

Report These Patients by the Appropriate Age Groups:

	COL. 1 < 45	COL. 2 45-54	COL. 3 55-64	COL. 4 65-74	COL. 5 75-84	COL. 6 85-94	COL. 7 95 +
4. White	_____	_____	_____	_____	_____	_____	_____
5. Black	_____	_____	_____	_____	_____	_____	_____
6. Hispanic	_____	_____	_____	_____	_____	_____	_____
7. Asian	_____	_____	_____	_____	_____	_____	_____
8. Filipino	_____	_____	_____	_____	_____	_____	_____
9. Pacific Islander	_____	_____	_____	_____	_____	_____	_____
10. Native American	_____	_____	_____	_____	_____	_____	_____
11. Other	_____	_____	_____	_____	_____	_____	_____
12. Total	_____	_____	_____	_____	_____	_____	_____

C. RACE /ETHNICITY AND AGE OF FEMALE LTC PATIENTS ON DECEMBER 31.

Report These Patients by the Appropriate Age Groups:

	COL. 1 < 45	COL. 2 45-54	COL. 3 55-64	COL. 4 65-74	COL. 5 75-84	COL. 6 85-94	COL. 7 95 +
13. White	_____	_____	_____	_____	_____	_____	_____
14. Black	_____	_____	_____	_____	_____	_____	_____
15. Hispanic	_____	_____	_____	_____	_____	_____	_____
16. Asian	_____	_____	_____	_____	_____	_____	_____
17. Filipino	_____	_____	_____	_____	_____	_____	_____
18. Pacific Islander	_____	_____	_____	_____	_____	_____	_____
19. Native American	_____	_____	_____	_____	_____	_____	_____
20. Other	_____	_____	_____	_____	_____	_____	_____
21. Total	_____	_____	_____	_____	_____	_____	_____

A. SUBACUTE CARE PATIENTS

1. Number of **Subacute** Care Beds Contracted for on 12/31..... 1._____

	COL. 1 Age 20 and Under	COL. 2 Age 21 and Over
2. Number of Subacute Patients in the Facility on 12/31.	_____	_____
3. Number of Subacute Patients Admitted During the Year.	_____	_____
4. Number of Subacute Patients Discharged During the Year.	_____	_____
5. Number of Subacute Care Patient Days.	_____	_____

B. PLACE *SUBACUTE* PATIENTS REPORTED ON LINE 3 WERE ADMITTED FROM:

10. Home	_____	_____
11. State Hosp	_____	_____
12. Residential Board and Care	_____	_____
13. Hospital	_____	_____
14. Other LTC	_____	_____
15. Specified Other	_____	_____

C. PLACE *SUBACUTE* PATIENTS REPORTED ON LINE 4 WERE DISCHARGED TO:

20. Home	_____	_____
21. State Hospital	_____	_____
22. Residential Board and Care	_____	_____
23. Hospital	_____	_____
24. Other LTC	_____	_____
25. Specified Other	_____	_____
26. Death	_____	_____

D. REPORT THE NUMBER OF *SUBACUTE* PATIENTS ON 12/31 THAT REQUIRED THE TREATMENT/PROCEDURES LISTED. (A patient may require more than one treatment/procedure:)

31. Tracheostomy with Ventilator	_____	_____
32. Tracheostomy without Ventilator	_____	_____
33. Tube feeding (nasogastric or gastrostomy)	_____	_____
34. Total Parenteral Nutrition (TPN)	_____	_____
35. Physical Therapy	_____	_____
36. Speech Therapy	_____	_____
37. Occupational Therapy	_____	_____
38. IV Therapy	_____	_____
39. Wound Care	_____	_____
40. Peritoneal Dialysis	_____	_____

COMPLETE ONLY IF YOUR FACILITY HAS LICENSED ACUTE PSYCH OR PHF BEDS

A. TOTAL ACUTE PSYCHIATRIC PATIENTS

	Line No.	PATIENT CENSUS DECEMBER 31
ACUTE PSYCHIATRIC TOTAL	1	*
Locked	2	
Open	3	

***TOTAL must equal Line 20, Column 1, Page 8**

B. TOTAL ACUTE PSYCHIATRIC PATIENTS BY AGE CATEGORY

AGE GROUP	Line No.	NUMBER OF PATIENTS
TOTAL PATIENT CENSUS	6	*
0-17 Years	7	
18-64 Years	8	
65 Years and over	9	

***TOTAL patient census (Line 6) must be equal to total acute psychiatric patients (Line 1 above)**

C. CDRS PROVIDED IN LICENSED ACUTE PSYCHIATRIC BEDS

Line No.	CENSUS **12/31** (Column 1)	For Calendar Year DISCHARGES (Column 2)	For Calendar Year PATIENT DAYS (Column 3)	STATE USE ONLY BEDS ON LICENSE (Column 4)
15				

D. Number of patients from census of 12/31 per primary reimbursement source

SOURCE	Line No.	NUMBER OF PATIENTS
TOTAL ACUTE PSYCHIATRIC PATIENTS*	20	
Medicare	21	
Medi-Cal	22	
Short-Doyle (includes Short-Doyle Medi-Cal)	23	
HMO	24	
Other Third Party Payment	25	
Private Pay	26	
Other	27	

***Total acute psychiatric patients (Line 20) must be equal to total patient census (Line 6) and acute psychiatric total (Line 1)**

E. During the calendar year, did you provide any acute psychiatric care under a Short-Doyle contract? (1-Yes, 2-No) . 30. ____

A. INPATIENT BED UTILIZATION - ***DO NOT INCLUDE NORMAL NEWBORNS IN BED UTILIZATION DATA ON THIS TABLE!***

Line No.	CENSUS 12/31 (Col.1)	STATE USE ONLY Licensed beds (Col. 2)	**BED CLASSIFICATION** AND BED DESIGNATION[1]	For Calendar Year: Hospital Discharges (Including Deaths) (Col. 3)	For Calendar Year: Intrahospital Transfers From Critical Care (Col. 4)	For Calendar Year: Patient Days (Census Days) (Col. 5)	STATE USE ONLY Licensed Bed Days (Col. 6)
1			Medical/Surgical[2] (Include GYN)				
2			Perinatal { • *Exclude newborn* • *Exclude Gyn*				
3			Pediatric				
4			Intensive Care[3]				
5			Coronary Care[3]				
6			Acute Respiratory Care[3]				
7			Burn Center[3]				
8			Intensive Care Newborn Nursery[5]				
10			Rehabilitation Center[4]				
16			**SUBTOTAL--General Acute Care**				
18			**SUBTOTAL--Chemical Dependency Recovery Hospital**				
20			**SUBTOTAL--Acute Psychiatric** Please complete Page 7				
25			**SUBTOTAL--Skilled Nursing**[6] Please complete Page 4				
30			**SUBTOTAL--Intermediate Care**[7] Please complete Page 4				
40			**HOSPITAL TOTAL**[5]				

[1] See instruction booklet

[2] Licensing replaced the Medical/Surgical designation with "Unspecified General Acute"

[3] Critical care-staffing ratio minimum of one (1) RN for every two patients Step-down utilization (observation, telemetry, etc.) should be reported as Medical/Surgical (Line 1)

[4] Physical (muscular/neurological) rehabilitation

[5] ICNN is one (1) RN to two (2) infants or less

[6] From page 4, Line 4, Column 1 and 3

[7] From page 4, Line 4, Column 2 and 4

B. Complete the table below if you **provided** Chemical Dependency Recovery Services (CDRS) **in your licensed General Acute Care Beds** (subtotaled on line 16 above). Do not include data below if the service was provided in licensed CDR Hospital beds (reported on Line 18 above), nor if provided in licensed Acute Psychiatric beds (reported on Page 7).

CDRS PROVIDED IN **LICENSED GENERAL ACUTE CARE** BEDS

Line No.	CENSUS DECEMBER 31 (Column 1)	For Calendar Year: DISCHARGES (Column 2)	For Calendar Year: PATIENT DAYS (Column 3)	STATE USE ONLY: BEDS ON LICENSE (Column 4)
45				

CARDIAC CATHETERIZATION AND CARDIAC SURGERY SERVICES

COMPLETE THIS PAGE ONLY IF "CARDIOVASCULAR SURGERY SERVICES" OR "CARDIAC CATHETERIZATION LABORATORY ONLY" APPEAR ON YOUR HOSPITAL'S LICENSE DURING THE REPORTING YEAR.

State Use Only
3 _____

CARDIAC SURGERY: PLEASE REFER TO THE INSTRUCTION MANUAL BEFORE COMPLETING.
Enter "0" if the answer is none or the question does not apply

A. Of the total number of operating rooms reported on Page 11, how many were equipped on 12/31 to perform cardiac surgery with extracorporeal bypass?..... 10 _____

B. How many cardiac surgery operations with extracorporeal bypass were performed during the calendar year?

	Line No.	Cardiac Surgery with Extracorporeal Bypass
Pediatric	11	
Adult	12	
TOTAL	13	

CARDIAC CATHETERIZATIONS: PLEASE REFER TO THE INSTRUCTION MANUAL BEFORE COMPLETING.
Enter "0" if the answer is none or the question does not apply

A. How many rooms in your hospital on 12/31 were equipped to perform Cardiac Catheterizations..... 20 _____
Report the utilization of these rooms below:

B. "Cath Lab" Utilization

	Line No.	PATIENT VISITS	
		Cardiac Catheterizations	
		Diagnostic (Col. 1)	Therapeutic (Col. 2)
Pediatric	23		
Adult	24		
TOTAL	25		

NOTE: DO NOT INCLUDE ANY OF THE FOLLOWING AS A CATHETERIZATION

Angiography
Automatic Implanatable Cardiac Defibrillator (AICD)
Defibrillator (AICD)
Cardioversion
Intra-Aortic Balloon Pump
Percutaneous Transluminal (Balloon)
Angioplasty (PTA) (non-cardiac)
Pericardiocentesis
Temporary Pacemaker Implantation

C. Distribution of Therapeutic Cardiac Catheterizations by Type

TYPE	Line No.	NUMBER (Col. 1)
Permanent Pacemaker		

BIRTH AND ABORTION DATA

A. Enter the number of the following events which occurred in your hospital during the calendar year. If a particular event did not occur in your hospital, enter a "0".

Line No.	EVENT	TOTAL OCCURRING IN HOSPITAL
6	Total Live Births (Count multiple births separately)[1]	*
7	• Live Births with Birth Weight Less Than 2500 grams (5lbs. 8 oz.) [2]	
8	• Live Births with Birth Weight Less Than 1500 grams (3lbs. 5 oz.) [2]	
9	Induced Abortions Inpatient[3]	
10	Induced Abortions Outpatient (ambulatory)[3]	

*The number of births shown on this line should be approximately the same as the number of discharges shown on Page 8, Line 2, Col. 3. Include the number of LDR or LDRP births on appropriate lines(s) in table above.

B. Enter the number 1 (yes) if the facility had an alternative setting .....11 _____
(i.e. an approved birthing program)

	LDR[4]	LDRP[4]
If yes, your alternative setting was approved as (check correct alternative) 12	_____ (Col. 1)	_____ (Col. 2)

How many of the live births reported on line 6 occurred in your alternative setting?.....13 _____
Do not include C-Section deliveries.

How many of the live births reported on line 6 were Cesarean Section deliveries? .....14 _____

[1] **LIVE BIRTH**

The complete expulsion or extraction from its mother, in a hospital, of a product of conception, irrespective of the duration of pregnancy, which after such separation, breathes or shows any other evidence of life such as beating of heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered live born. When more than one live product of conception is expelled (multiple birth), each one constitutes a separate live birth. EXCLUDE live births occurring outside your hospital.

[2] **LIVE BIRTHS UNDER 2500 GRAMS; UNDER 1500 GRAMS**

Of the total live births, how many weighed less that 2500 grams (5 lbs., 8 oz.); of the births weighing less than 2500 grams, how many weighed less than 1500 grams (3 lbs., 5 oz.)?

[3] **INDUCED ABORTIONS**

Intentionally induced abortions (chemically or surgically), performed on an outpatient or inpatient basis, irrespective of gestational age.

[4] **LDR (Labor, Delivery and Recovery) and LDRP (Labor, Delivery, Recovery and Post-Partum)**

LDR is a program for low-risk mothers with stays of less than 24 hours, including equipment and supplies or uncomplicated deliveries in a home-like setting and that has been approved by the Division of Licensing and Certification, Department of Health Services (L&C). LDR replaces ABC (Alternative Birthing Center).

LDRP is a program similar to LDR but is not limited to low-risk deliveries and the stays are usually for more than one day. LDRP also is L&C approved.

C. Enter the number of well baby** days..... 15 _____
**These are normal newborn nursery days.

SURGICAL SERVICE

A. In the table below, enter the numbers requested. If an item does not apply or the answer is "none" enter a "0".

	Line No.	FOR CALENDAR YEAR	
		Number of Surgical Operations (Col. 1)	Operating Room (Anesthesia) Minutes (Col. 2)
Inpatient	1		
Outpatient	2		

- **Surgical Operations** -- A surgical operation is one patient using a surgery room. Therefore, a surgery involving multiple procedure (even multiple, unrelated surgeries) performed during one scheduling is to be counted as one surgical operation. This definition of a surgical operation could also be termed a "patient scheduling."

- **Operating Room Minutes** -- The difference, in minutes, between the beginning of administration of GENERAL anesthesia, and the end of administration of GENERAL anesthesia.

The only exception: if the general anesthesia continues after the patient leaves the operating room, then ending time occurs when the patient leaves the operating room.

IF GENERAL ANESTHESIA IS NOT ADMINISTERED, starting and ending time are defined as the start and end, respectively of the surgery.

B. Enter the number 1 if during the reporting year, you had an organized ambulatory surgical program? i.e., Did you have written policies, procedures, and quality of care standards specific to outpatient surgery patients?.....5 _____

C. ***On December 31***, what was the number of surgical operating rooms in your surgical suites(s)? (Include special procedure rooms, i.e., cystoscopy rooms, cardiovascular surgery rooms, and other rooms in which surgeries were performed) .....10 _____

D. Of the total operating rooms specified in Item C, how many were used during the calendar year:

Exclusively for outpatient surgery?.....11 _____

Partially for outpatient surgery?.....12 _____

Exclusively for inpatient surgery? .....13 _____

RADIATION THERAPY SERVICE
(Megavoltage Machines Only)

A. If Radiation Therapy Services appear on your hospital's license, do you provide the service? (1-Yes, 2-No)..... 1 ____

If Yes, please complete Section B.

State Use Only
2 ____

SECTION B. INSTRUCTIONS:

In the table below, complete one line for each megavoltage machine in your Radiation Therapy Service.

Col. 3 Those days the machine was available for use including weekends, holidays, etc. Include only days the machine could have been used: do not include down time.

Col. 4 Treatment Visits" means a patient visit during which radiation therapy was performed.

B. Please list each megavoltage machine.

Line No.	Machine Number	TYPE OF MACHINE 1 = Linear Accelerator 12MeV & Under 2 = Linear Accelerator Over 12 MeV 3 = Cobalt 60 4 = Betatron 5 = Van de Graff Col. 1	Year Operational In Hospital Col. 2	Total Machine Days in Operation Col. 3	Number of Treatment Visits Col. 4	FOR LINEAR ACCELERATORS Maximum Voltage (MeV) in Photon Mode Col. 5	Electron Mode Col. 6
10	1						
11	2						
12	3						
13	4						
14	5						

EMERGENCY MEDICAL SERVICES

A. ***On December 31***, what was the number of patient treatment stations available? (A treatment station is a specific place within the emergency department adequate to treat one patient at a time. Do not count holding or observation beds) ..... 26 _____

B. What was the total number of patient visits to the EMS during the calendar year?..... 28 _____
DO NOT INCLUDE employee physicals and other scheduled visits.

C. What was the number of NON-URGENT EMS* visits during the calendar year? ..... 29 _____

D. What was the number of URGENT EMS* visits during the calendar year?..... 30 _____

E. What was the number of CRITICAL EMS* visits during the calendar year?..... 31 _____

F. What was the number of EMS visits that resulted in hospital admissions? ..... 32 _____

(*See definitions in Instruction Booklet)